V. S. No. 2
0M—9-4-41
Rev. 5-17-39
I X29484

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 17645

FILED JUN 8 1944

Registration District No. 17

Primary Registration District No. 3008

Registrar's No. 170

14 / 2

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2 State Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9y-10m-24d (Specify whether

In this community 9y-10m-24d years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson 14

(c) City or town Kansas City, Mo. 2
(If outside city or town limits, write "RURAL")

(d) Street No. 1902 E. 19th St.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Garfield Dann

3. (b) If veteran, name war DK.

3. (c) Social Security No. DK.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, 2 divorced widower

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased DK (Month) (Day) 1904? (Year)

8. AGE: Years 40 | Months | Days | If less than one day hr. min.

9. Birthplace Oklahoma (City, town, or county) (State or foreign country) 1

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER

12. Name Sam Dare Dann 9

13. Birthplace DK (City, town, or county) (State or foreign country)

14. Maiden name Mary Schippas 9

15. Birthplace DK (City, town, or county) (State or foreign country)

16. (a) Informant Records

(b) Address

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 19-1944 (Month) (Day) (Year)

(c) Place: burial or cremation Hospital Grounds

18. (a) Signature of funeral director C. E. Thomas

(b) Address 309 Market St. Fulton, Mo.

19. May 19-44 (Date received local registrar) (b) Joan Monnich (Registrar's signature)

1147

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 17 year 1944 hour 9 7:45 P M.

21. I hereby certify that I attended the deceased from 5-1, 1942 to 5-17, 1944 that I last saw h~~im~~ alive on 5-17, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Generalized Acute Miliary Tuberculosis	WEEKS
Due to Bronchopneumonia (Massive - Bilateral)	5 days
Due to	
Other conditions (Include pregnancy within 3 months of death)	

PHYSICIAN — Underline the cause to which death should be charged statistically.

Major findings: Of operations as above in cause of death

Of autopsy as above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature J. B. Stokes, M.D. (M. D. or other)

Address Fulton, Mo Date signed 5-17-44

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 6-7-44

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.